VIRAL SEROLOGY TEST REQUEST

1. **Please provide the patient information requested.**
2. **Type or print with pressure.**
3. **Send all copies of this form with specimen to STATE PUBLIC HEALTH LABORATORY.**

PATIENT NAME (LAST, FIRST)

ADDRESS (CITY, STATE, ZIP CODE)

BIRTHDATE

SEX ☐ Female ☐ Male

RACE W | B | A/PI | AI/AN | O/U

MEDICAID NUMBER

The following information MUST BE PROVIDED before testing can be performed:

PERSON'S NAME AUTHORIZED TO RECEIVE PHONE RESULTS

FACILITY/LAB PHONE NO.

FACILITY/LABORATORY NAME

FACILITY/LABORATORY STREET/MAILING ADDRESS

FACILITY/LABORATORY CITY, STATE & ZIP CODE

DATE SPECIMEN COLLECTED

ACUTE

CONV

ONSET

RUBEOLA/RUBELLA VACCINATION HISTORY

TEST REQUESTED:

Please indicate below, see back of form for test description.

☐ Measles (Rubeola) IgM EIA

☐ Rubella IgM EIA

☐ Arbovirus

☐ Rickettsial Panel

☐ Other: CDC Referrals

DATE RECEIVED

ACUTE

CONV

DATE CONV. REQ'D

STATE LAB SERIAL NO.

FOR STATE HEALTH LAB USE ONLY

DATE REPORTED

LABORATORY REPORT

RUBEOLA EIA (IgM): ☐ Positive ☐ Negative ☐ Equivocal

RUBELLA EIA (IgM): ☐ Positive ☐ Negative ☐ Equivocal

MISSOURI DEPARTMENT OF HEALTH
STATE PUBLIC HEALTH LABORATORY
307 W McCARTY, PO BOX 570
JEFFERSON CITY MO 65101

EOAA EMPLOYER
Services Provided on a non-Discriminatory Basis